Chiro-Health, Inc - Financial Policy

Thank you for choosing our practice! We are committed to the success of your care and understand that payment of your bill is part of this care. Please read our policies bellow, ask us any questions you may have, and sign/initial in the space provided. A copy of this policy will be provided to you upon request.

Definition: ***Co-Insurance*****:** Co-insurance refers to the percentage of medical care that the insured is responsible for paying. The insured will pay the full cost of care up to the deductible and will then become responsible for paying the co-insurance amount. For example, a person with 80-20 coinsurance will then become responsible for 20 present of medical care costs. ***Deductible*****:** The deductible is the amount that the insured must pay before the health insurer begins to pay for covered expenses. Foe example, a patient with a $1000 deductible would have to pay $1000 in covered medical expenses over the course of the year before the insurer would start to pay. ***Co-pay*****:** Co-pay is short for co-payment. It refers to the amount that an insured is required to contribute for specific types of medical care or treatment. For example, a patient might have a $20 co-pay for every doctor's visit. I have read this paragraph and fully understood the definitions in relationship to my insurance contract. I understand my portion of co-pay, co-insurance and deductible are my out of pocket expenses that I will be responsible for. _____ (please initial).

1. **Insurance**. If you are not insured by a plan we do business with, OR don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your covarage. If you fail to provide us with your insurance information prior to your appointment, or if we were unable to confirm your benefits due to out of state insurance prior to your appointment, you will be responsible for the balance of any claim. _____(please initial).

2. **Co-payments, co-insurance and Deductibles**. All co-payments must be paid at the time of service. You will also be responsible for paying a partial deductible on every visit until you meet this deductible at the time of service. _____ (please initial).

3. **Claim submission.** We will bill your health insurance company directly. **Please be aware that the balance of your claim including co-insurance and deductible is your responsibility whether or not your insurance company pays our claim.** Your insurance is a

contract between you and your insurance company; we are not a party to that contract. _____ (please initial).

4. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45days, regardless of the reason for not paying, the balance will automatically become your responsibility. _____ (please initial).

5. **Non covered services or not medically necessary services according to the insurance.** One hour massage, acupuncture, ART (Active Release Technique) and other non covered services must be paid in full at the time of visit. You may use your flexible spending account (FSA) for these non-covered medical related services. _____ (please initial)

6. **Patients without health insurance.** Payment in full is required at the time of your appointment. _____(please initial).

7. **Missed appointments.** Please understand that when you do not cancel an appointment you are unable to keep, it prevents other patients from receiving care they need. **Therefore, our policy is to charge $65 for missed appointments not cancelled within 48 business hours of the appointment time.** For example if you leaving a message on Friday night cancel an appointment for Monday or Tuesday morning, that is not considered a 48 business hour notice. If an emergency arises, please notify us as soon as possible. A make-up appointment will be assigned and reserved for you within the same week based on availability and you will not be charged for rescheduling. _____ (please initial)

I have read and understand the payment and cancelation policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party Date

_____

Printed name